Jefferson Health Access Summit 2001

May 22, 2001

Summary

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Health Access Summit 2001

Summary

On May 22, 2001 over 50 people met in Port Hadlock to discuss issues related to health care access in Jefferson County, Washington. The Summit was presided over by Chuck Russel, Chair, Jefferson General Hospital Commissioners and Jill Buhler, Chair, Jefferson County Board of Health. Prior to the Summit the Hospital Commissioners for Jefferson General Hospital and the Jefferson County Board of Health met jointly over a nine month period to discuss ways to improve local access to care. The joint boards appointed a workgroup of community leaders to examine the issues more closely and plan a community Health Access Summit. The workgroup developed a list of ideal health system goals and a report containing some of the information they discussed. A summary of the report and the ideal health system goals were distributed to participants before the Summit.

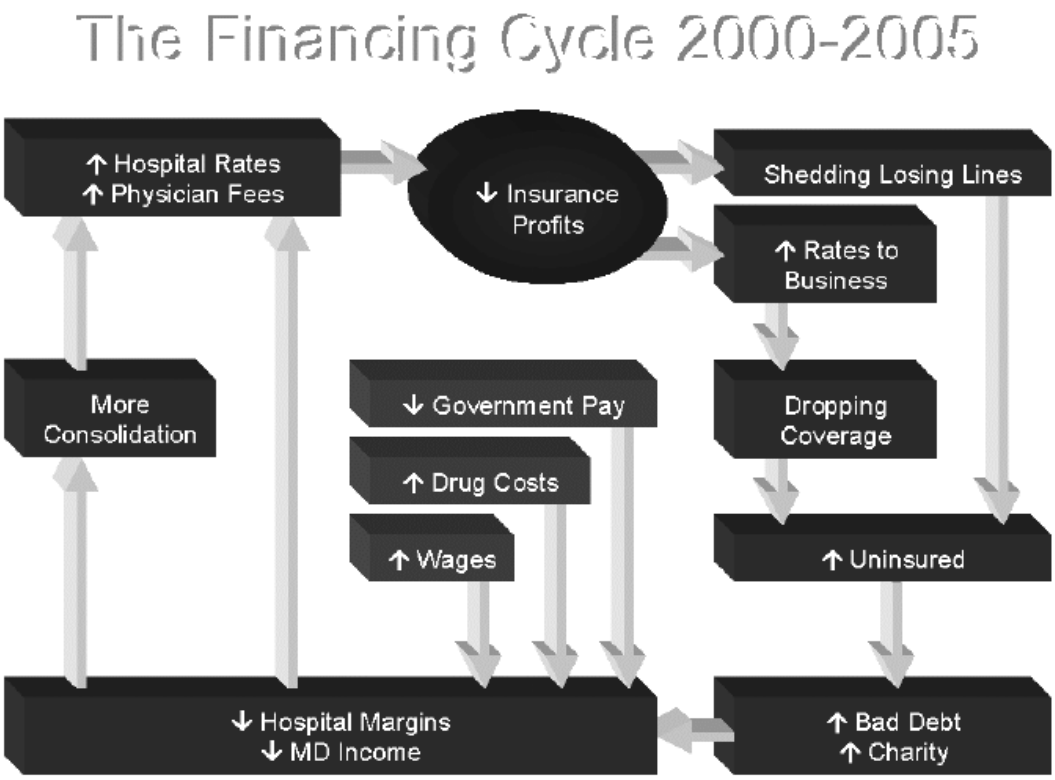
The purpose of Health Access Summit 2001 was threefold:

1. Gain a better understanding of the problems confronting the Jefferson health care system from a variety of perspectives;
2. Assess the level of concern among Jefferson County community leaders about health system problems;
3. Determine whether or not there is an interest in pursuing a community-based, cooperative effort to develop and implement specific solutions to identified problems.

Leo Greenawalt, Washington State Hospital Association, and **Greg Vigdor**, Washington Health Foundation, presented information about state-wide health access and financing isssues.

- In the early 1990's Washington State had one of the lowest uninsured rates in the nation. This is no longer true.
- Costs for health care are expected to increase 15-20% per year into the foreseeable future.
- Urban areas are better able to weather the storm while rural areas will be hit much harder.

The financing cycle chart below shows the complicated chain of events that contribute to current health system problems. The situation is not good right now, is not going to get better, is probably going to get worse, but people do not seem ready to change.



Never have so many bright, good people tried to do so much in such a dysfunctional system.

The Washington Health Foundation's Future of Rural Health Program is a 5-10 year project to look for new models. The Foundation believes the ingredients for success are dealing with costs/financing, access, quality of care, the health of the community and sustainability.

- At least 600,000 people in Washington don't have any health insurance, even more are underinsured.
- If the state economy takes a downturn, sustaining even the current level will be difficult.

Tom Locke, MD, **MPH,** Jefferson County Health and Human Services, discussed the problem from a public health perspective.

- Even though only about 1% of health funding goes to public health, it has a much larger role in potential solutions.
- Jefferson County has a rapidly growing population of elderly residents, large proportion of transfer income (rather than wages), an expanding gap between the poor and the rich.
- Jefferson County Health and Human services is a significant service provider with more than 900 family planning patients and other active direct care programs.

These programs are vulnerable to the same financing problems destabilizing the medical care system.
- 100% access and 0% health disparities is a goal but we need to ask and answer "access to what?" Can we afford everything or do we need to make conscious and difficult choices? The Washington State Board of Health has developed a list of critical health services as a starting point for setting priorities.
- We need to build community partnerships to effectively fill the disparity gaps.

Tim Caldwell, Port Townsend Chamber of Commerce, spoke about his involvement in local discussions to start a physician hospital community organization after the 1993 state health reform legislation (which was repealed). In reality, health system issues have many sides. Many businesses in Port Townsend are small - 2 or less employees. People can see many of the issues but don't know how to fix the problems. The Chamber is able to offer a KPS group health plan to members and this has been an incentive for new membership. With many new retirees moving to the area, we've seen so many different health plans that it's difficult to have the critical local mass to negotiate contracts. Somehow we need to get people to sit down in the same room and ask how we can organize something for both workers and retirees.

David Beatty, Olympic Area Agency on Aging, discussed their role in serving older and disabled adults in the 4 counties of the Olympic Peninsula. Funding comes from the Older Americans Act and Medicaid. More and more seniors can't pay for prescription drugs or utilities or home repairs. People are having difficulty finding local doctors or dentists who take Medicare or Medicaid reimbursement. Access to in-home care helps seniors remain independent.

Brent Shirley, Brent Shirley and Associates, discussed trends in the local health insurance market.
- Premiums are rising – 15-33% increase in rates this year (more for some employers).
- Everyone is being blamed for the problems but the fact is that the system isn't working well for anyone.
- There are fewer health insurance plans available – many have merged or gone out of business.
- The pre-existing condition waiting period has increased from 3 to 9 months and people applying for new individual health insurance policies must fill out a 14 page health questionnaire. Plans can reject up to 8% of applicants.
- Health care costs are rising again due to increasing prescription drug costs, technology and expectations of people.
- Benefits mandated by the legislature have also driven up costs.
- Medicaid and Medicare payments are being reduced relative to costs. Medicare program regulations consist of about 2,500 pages.
- In 1990 the answer to rising costs and access was managed care. Plans were restructured to meet business needs – not community needs.
- Focus has been on solving cost problems – not health problems.

Melanie McGrory, MD, Olympic Primary Care, discussed the unique stresses of community physicians.

- The current system is in shambles.
- People need information and reassurance about their health. The current system makes it increasingly difficult to provide these essential services.
- Primary care physicians need time and technology. It's difficult to give patients the time and the technology they need in a 10-15 minute visit.
- The costs of regulation for documentation and other administrative demands take up about 50% of a physician's time.
- Physicians are also required to negotiate contacts with plans, police their peers, invest in office space and run a business – none of which was taught in medical school.
- 14% of our gross national product is spent on health care and more and more time is spent on work not related to patient care.
- Medical practices are failing as businesses across the state. In Olympia 10 primary care physicians are quitting leaving 20,000 people without a doctor.
- Most physicians went into practice to take care of patients but now the work has become very dehumanizing and many physicians can't even make a living being a doctor any more.

Vic Dirksen, Jefferson General Hospital, said we need more people like Melanie to speak up about the issues.

- Jefferson General Hospital might be able to capture ½ to 1/3 of the hospital care that is provided in other communities, but some should go to facilities that can provide services that will never be available locally because of the small number of cases.
- Government financed care is reducing payments relative to costs and is having a disruptive impact locally. Under the current projections, the Balanced Budget Act will eliminate the hospital's reserves by 2003. State budget problems may require cuts in Medicaid and Basic Health eligibility, benefits and reimbursements.
- The charity care provided by the hospital is increasing and is another symptom of local problems. Last year at this time charity care totaled about a million dollars. This year it's about 1.5 million dollars out of a 20 million dollar budget.
- An important piece of the access puzzle is finding a way to care for the most physically and financially vulnerable residents. If we leave them behind, we've failed.
- Physician recruitment is a looming problem.
- The Commissioners have decided to keep "unprofitable" services, unlike many other hospitals and health care providers. The hospital has taken a number of steps to redesign services and work with local physicians to see how everyone might be more successful.
- The hospital has also been working with the Jefferson County Board of Health to address some of the health system and financing problems locally.

A Summit discussion included the following comments and questions.

The rising costs of prescription drugs are a complicated problem. Because many of the major drug companies are multi-national corporations controlling them through regulatory means is difficult, although some other countries do regulate what they can charge. The US has chosen not to do this.

One success in the health system has been increasing coverage for kids. Unfortunately the rate of preventive services has declined. Therefore some kids get diagnosed later. One reason is that it takes time to do the screening tests but economic pressures don't always allow adequate time during a visit. An example is that Basic Health says they cover a particular service, but they don't pay providers an adequate reimbursement to really do it, so it's not really adequately funded by the state.

Another issue is provider liability. Reform of this system could save money.

In rural communities, everyone is in it together. We need more answers and models for how health care can work in rural areas. The market based system may work in urban areas but it can't work in rural areas.

In some areas creative employer based preventive programs have had success.

Health workforce shortage issues are looming. We need the ability to attract top-notch providers. The health system and providers will also be important for attracting new business to the area.

Why hasn't government jumped on the economic development bandwagon in terms of sustaining rural health systems? Economic vitality requires a local health system. This might be a way to get economic assistance.

One issue that can't be ignored is risk. Prevention helps but if there is an insurance based system or strategy, you need to deal with risk (of catastrophic health costs). The state will never return to a fee-for-service system and communities that want to be innovative have to find ways to deal with risk. The state has talked about some models like the Primary Care Case Management for Medicaid.

The state used to take all risk for publicly funded coverage. When they began contracting with managed care plans for Medicaid and Basic Health, they washed their hands of any local problems caused by the plans. They expected the plans to deal with everything for them. The plans pay local providers what ever they want and the state doesn't interfere. Before a community could take risk, they would have to be sure that the payment from the state was adequate to pay for the services. Right now it isn't.

Geoff Masci, Board of Health and Workgroup Member, presented information about the work that let to the Summit. The workgroup was composed of individuals from: Jefferson General Hospital, Jefferson County Board of Health, Chamber of Commerce, Area Agency on Aging Director, Port Townsend Paper Mill, Insurance Broker, Physician

Chief of Staff, United Good Neighbors, Jefferson County Administrator, Washington Health Foundation, Olympic Peninsula Community Action, small business owners, City of Port Townsend.

The workgroup looked at what could be done at the local level to organize the financing and delivery of health services. The met and:

- Identified reformed heath system goals
- Researched issues and invited experts to discuss options
- Coordinated a local health summit to educate community and discuss situation.

Health care is big business in Jefferson County:

- $91.2 million spent on personal health care services for Jefferson County Residents (1997)
- 15% of total economy
- $60 million spent in the County (1997)
  - 35% Federal funds (Medicare and Medicaid)
  - 32% Private health insurance
  - 19% Out of pocket (Self-pay, copay and deductible)
  - 10% State and Local funds (Medicaid, Basic Health)
  - 4% Other funds

Why is our health system struggling?

- Medical practices across the state are going bankrupt - physicians leaving Washington.
- Medicaid, Medicare and Basic Health reimbursement is so low jeopardizes hospital and physician's solvency.
- 53% of hospital revenue comes from Medicare (compared to 33% statewide)
- Medicare will continue to cut payments to hospitals.
- 3,000 – 7,000 residents have no health insurance.
- Employers are having a harder time paying for health benefits.
- Many seniors on Medicare can't afford prescription drugs.
- State budget cuts in health care are expected over the next several years.

The workgroup developed a list of ideal health system goals. The purpose of the goals is to develop a flexible document that can guide local efforts to improve access to health care. The goals or desired outcomes of re-designing the financing and delivery of health care services in East Jefferson County are broad value statements. The goals will be used to discuss and evaluate the relative merits of models or proposed system changes.

- **Access to Care.** The broadest range of services that can be provided locally will be available to all East Jefferson County residents, particularly the most physically and financially vulnerable.

- **Quality of Care.** The quality of health services will be continually improved.
- **Funding Sources.** To the greatest extent possible, funding sources will be organized to better support the local health care system.
- **Spending Impacts.** Health care system funding will be directed to improve the health and quality of life of East Jefferson County residents.
- **Medical Practice Viability.** East Jefferson County providers will be supported by the community to ensure the continued availability of their services.
- **Incentives to Improve Health.** Prevention and public health will be important components of the model.
- **Administrative Functions.** A local, publicly accountable entity will manage administrative functions in a way that improves access, supports local health services and redirects as much funding as possible to direct heath care services.
- **Patient Autonomy.** Patients should have the greatest range of choices possible within the financial limitations of the system.
- **Physician Clinical Decision-making Autonomy.** Cost containment and clinical autonomy will be balanced through quality improvement activities.
- **External Factors.** External factors will be continually monitored to take advantage of beneficial developments and address disadvantageous changes.
- **Future Demographic Factors.** Health System changes should be designed to accommodate the changing demographics and needs of the East Jefferson County population.
- **Personal Responsibility.** Incentives should be built into the system to encourage individuals to take personal responsibility for their health and the services they need.
- **Occupational Support.** The system will incorporate special programs and services that will help impaired and disabled East Jefferson County residents maintain or regain physical functioning to participate as members of the local workforce and community.

Summit participants formed four discussion groups. The following is a partial summary those conversations.

Discussion Group 1 facilitated by Julia Danskin.

- What issues are involved related to Jefferson County's population not being large enough to be able to create it's own health plan.? Brent Shirley had said in the morning session that maybe a plan could include other rural communities. Could we get more information for the joint boards on how many people would we need to consider creating a local insurance group?
- The number would have to be large enough to cope with the variability in numbers; KPS is small at 40,000 members. All of Jefferson county is only 27,000.
- Liability is a huge expense that doesn't contribute to client care. Would like some discussion and ideas on how we could bring this to the legislators for some policy help.
- What are the major policy decisions that have unexpected impact at the local level? What are the larger policies that have forced the health care system to become this

way? Is there any new legislation that would prevent us from moving ahead with solutions we might come up with?

- There were no solutions coming from the state or federal government at this time. What would the physicians want if we had a magic wand: Less administration cost or less liability cost?
- What about the underserved. Why don't we have a community Clinic? The argument about not wanting a 2-tiered system doesn't hold. We already have a two-tiered system. What is the basic Level of Health Care and what are extras? (Oregon was able to come up with what it would pay for and what was extra.) How come Kitsap has 3 community clinics and Jefferson Co. has none? (Actually, Jefferson has a rural health clinic in Quilcene.) Physicians can get their liability paid by the government if they work in a federally designated underserved area.
- How was Oregon was able to ration health care?
- Oregon went though a ranking by all the citizens on what health care was most important and least important to pay for. The legislature priced out the services and looked at how much money it had then decided what it could pay for. The problem is they only applied it to the Medical Assistance coverage (Medicaid).
- What is the latitude on alternative sources of funding. What can we build on? The wrong people are getting beaten up, ie the Doctors. We need to build a fence around Health Care. Until the Physicians have control we won't have a good health care system. Local Dr. have to compete with the city.
- Not all agreed. Some thought cost controlled health care. With high deductible health insurance policies, can't afford to go shopping for a Dr. that will just give you want you want.
- What are the macro issues at policy level that are impacting local businesses, like 52% increase in KPS premium for Olycap that had a huge impact on their budget? Also what about solutions like prevention, triage, and wellness programs like Sandra talked about in the am?
- Will have to face limiting care, Recognize reality. If a group like this could come up with what is feasible then (KPS) is willing to talk.
- What about mental health and dental. Many medical problems come from mental health problems. If we don't treat dental problems they become medical problems.
- Need to look at access and rural. When the Chamber of Commerce looks at opportunities for higher education they can't get it locally. What is minimum care? Is transportation the solution? Do we downsize the hospital?
- It would be a failure if Jefferson General Hospital got smaller. When a loved one is in the hospital it is better for them to be closer to their friends and family to visit.
- It is expensive to have employees have to take a whole day off work to go to an appointment in Seattle when if they could get the care in town they might only be out for an hour. Also the care may not be any cheaper in Seattle.
- The State BOH has been working on what essential health services are.
- People have been working on lists of essential services that have been published over the years. No one ever looks at them.
- There was a time dialysis was rationed. In Europe if you are over 50 years old you may not qualify for dialysis. The cost of a liver transplant for an ex IV drug user or alcoholic is questionable.

- Rationing is happening now by person not by treatment. Either you get care or you don't get care. It would be nice to make the choices consciously not by marketplace.
- Is a community Clinic an option?
- JGH had looked into community clinics and it wouldn't increase reimbursement because the federal government has no more money to put into community clinics.
- The JGH physicians are now part of the Rural Health Clinic with Quilcene. East Side Group Health did a franchise in the community with a 5 year agreement. Again, what are the right numbers? We don't have elements in community to provide all the services needed.
- Is there a need? What are people willing to commit to? Some people only buy insurance when they are sick and then drop it when they get well. What would it take to get a community wide commitment?
- What would it take to guarantee a stable population with controls on extras (insurance plan)? It would be an interesting idea.
- It would be nice to be able to budget 5 years out for employee premiums
- What part of the community is willing? There are different levels of desire. There are different levels of commitment. Need leadership from community. We are small enough to make a difference and what are you going to be willing to pay 5 years from now?
- There are small ways to reduce administrative cost by paying at time of service.
- Need preventative incentives.
- Can never guarantee that prevention can save money.
- Are regulations getting worse or better?
- HIPPA is making it worse, regulation are un-intergrated ways of solving problems.
- 70 years of policies and regulations. How do you argue compliance, fraud, privacy and patient record regulation? Can only make changes at the local level on how you implement regulations. Policies and regulations collide with overall goals
- Complicated billing. Need certain codes with some insurance billing and other codes with another plan.
- Will the local unions be willing to look at another insurance plan?
- Do we talk to the government first to see what is possible or go ahead with a plan?
- Go ahead with a plan. If you wait for the government you will be waiting a long time.
- The state government is interested in ideas and solutions.
- Specifically regarding Design Goals. Access to Care: what is minimum? On Spending Impact: "To improve the health and Quality of life" is outside medical care.
- What are Covered Services? That was what she was expecting from the work group. Also, under Patient Autonomy need to qualify "choices possible."
- Administrative Functions is the only goal that we can work on. One pot payer system.
- It seems the Goals collide with each other, what are the priorities.

Discussion Group 2 facilitated by Lorna Stone.

Is more information needed to understand the problem? Be as specific as possible.

- Rather than the average cost per person, it would be more helpful to know how the load is distributed (given stats on elderly population).
- Including complementary alternative medicine could double the cost per person. There is interest in this, but it would be very complicated to include.
- Dental should be included as an access issue.
- How much charity care is being given?
- Is anyone working on a community clinic as an option. The Jamestown S'Klallam Tribe is looking at setting up a clinic. They are able to get $184 per visit while some private doctors only get forty cents on the dollar. A clinic has been discussed about a year ago but it might be competitive with the hospital clinic.
- What about critical mass? Do we have an adequate size population to give a full range of services? Virginia Mason and Group Health couldn't make it here. The issue of the high level of transfer payments here influences demand and coverage. BRFSS study will help give some answers.
- Basic Health covers too many services. It's not as brave as the Oregon Health Plan. We need to get more information about how Oregon works.
- In the past people paid cash and the system seemed so much simpler. Why can't cash payments just be used to simplify things? There may be legal reasons why this won't work. For example some programs require that you can't give discounts for people who pay in cash.
- The idea of a local health authority makes sense but how would it work with employer based model or community clinics?

Do these problems effect you? If so, how?

- Even though there are 31 practitioners in Jefferson, only 13 are primary care doctors can admit people to the hospital. That's getting to a breaking point. More and more docs don't want to do on-call or inpatient work. It's burdensome for those who still do because no pay goes with it.

In general, do you support the health system goals drafted by the Workgroup?

- We should include health education as a goal. Education about both system financing and health.
- We need a schedule for coverage of services – essential services. The first goal of access is too broad. Maybe a shuttle to Seattle is more practical. We should just be doing what we can do really well here – what's feasible.
- The wording of the quality goal seems insulting – it seems to presuppose that we don't have high quality. Quality is an issue of perception as much as fact. There needs to be a lot of community education about this issue.
- Even people who should know better sometimes say things like we should have a cardiologist here. They don't understand that we would need several to handle call, new equipment and enough volume of procedures to support them and maintain the level of quality that is required. Expectations are really out of sync with reality. People need a better understanding of why some services are not available here.
- We need to add "financial" to personal responsibility.
- Can we get a good medical triage/management system built in?

- We need to emphasize incentives to improve health. Perhaps also rephrase to include cost savings.
- We need to deal with value added documentation. Right now the documentation required is so excessive it takes 50% or more of a physician's time. People want doctors to spend time with them not filling out forms.

Other issues

- The HRSA Community Access Program grantees are very interested in this work (federal grant program). There are 120 grantees looking at these issues and trying to find models that work. HRSA is also funding the Washington State access to insurance grant.
- The lawyers do a good job of campaigning for access to justice and funding through legal services. Access to health care.

Discussion Group 3 facilitated by Aaron Katz.

Key statement made by someone: "The health care system should be at least as good as Domino's Pizza."

Additional information needed.

- Percent of the health care dollar used up by insurance companies
- Outmigration of Jefferson County residents for health care elsewhere
  - What are the incentives to leave the area for care (intended and unintended)
  - Why do people leave for care (employment? Convenience?)?
  - What is people's perception of the quality of care in Jefferson County?
- Better data on insurance coverage rates for children
- Number of women who lose pensions and health insurance when their husbands die
- What are the challenges to employers in providing health insurance?
- What is the basis of insurance coverage (employment? Other?)?
- What percentage of the health care dollar is responsive to prevention?
- What is the public's expectation for basic health care? What constitutes basic care? What are the criteria?
- Is there community consensus of priorities?

How do problems affect you?

- Limited access to physicians because mine retired.
- Trouble recruiting physicians, because:
  - There are fewer family practitioners out there
  - Fewer medical students are going into primary care
  - Fewer physicians want to relocate
  - The demand to take a lot of call
- Issues are invisible, for example access to dental care due to DSHS low payment (dentists are forced to say "no" to DSHS patients) or issues regarding seniors
- DSHS's billing system stinks
- Referral processes – both public and private – each has its own rules and hoops
- Affordability – employers are struggling to provide coverage, but premiums are going up so they have to offer plans with $1000+ deductibles.
- Not enough choices of insurance products

- Limited funds generally – how do we decide which services to provide?

Support health system goals?

- Good statements, but very broad, "boilerplate," "bureaucratic"
- There should be a [community] vision statement that is tangible, about what a healthy community is; it should connote a "roll up our sleeves and work together" mentality, like the old barn raisings.
- How much is the public willing to take responsibility for their health?
- Work to make the existing system work better.
- Look at what's happening in other states and rural areas to find good models
- How well do the goals align with the IOM report?
- Develop work groups on each aspect of the problem:
  - Financing
  - Community voice
  - Data
  - Etc.
- Have work group members each describe a good model and then see what elements might work
- Ground rules: There are no dumb ideas; get disagreements out early in the process.
- The process could be a healing process, especially if it's a city-county partnership
- One possible approach – get every child in the community enrolled, then build on that with adults and seniors.
- Get better information to seniors.

Discussion Group 4 facilitated by Debby Peterman.

The group would like more information about the following:

- Number of primary care physicians that are declaring bankruptcy: How big of a problem is this in our community?
- What inducements are other communities offering physicians to attract them to their area? How are the offers being made?
- Why is our Medicare reimbursement so low? When was the last time that the AAPCC was adjusted? What can we do to increase reimbursement levels?
- How many and what kind of physicians does our community need? If national estimates are made, do these estimates take into account the demographics of our community and the fact that many of our doctors do not want to work full time or take call?
- Kris' data show the community spent $60 million on health care yet the community is saying that this is not enough. What is enough? What would it take to sustain our community's health care?
- If we created something like a health care trust fund or health care funding pool for our community, what are the obstacles we would face? E.g. risk, licensing. Who could provide risk and reinsurance for our small community? What would be the amount that we would need to seek reinsurance for? How big of a catastrophe?
- Can we do anything effective at the local level? Do we need to go to Olympia?

The problems identified by the group include:

- There are no incentives for people to take care of themselves. There is no reward (reduced health insurance) for healthy behavior.
- Employers can't afford to cover their employee's health benefits particularly for lower wage employees.
- Providers need to join together and communicate with each other when providing care. In home care providers are not linked to primary care, but they should be.
- The system is not in place to help people make hard choices. When is enough enough. Who decides who gets which services.

Goal discussion

- The goal, patient autonomy, talks about patient choice. Sometimes assuring choice is costly and can undermine our ability to do things. Quality is the key issue.
- Patient choice is a matter of degree. We want to be able to pick our physician.
- All of these goals are like motherhood and apple pie.
- Personal responsibility is a number one priority for some.
- Add the following goal: Redefine the health care system to be a coordinated, collaborative system.

Suggestions from the group on ideas to explore as solutions.

- We need to define a bottom line of services that every one will get. These need to include primary care and prevention at a minimum. For services beyond this baseline, the patient will need to pay more. (A two tiered health care system that provides a safety net.)
- We need to create a system that links together both health services and non health services to take advantage of what we have. – i.e new YMCA could do outreach and education to youth.
- We need to create a system that rewards people for healthy behavior.
- Pool all community health care funds into a common pot of money for community health care.
- Homogenize what we purchase. Band the community together to be one larger purchaser or contractor for health care services.
- Develop a report of our findings and share this with other rural areas. Have them do similar projects. Create a ground swell of rural communities and take our reports to Olympia.
- Establish a demonstration project and get resources to make changes locally. Identify ways that the community can be involved and help. Be up front about the fact that this will take a long time to make change. Don't offer unrealistic expectation.

Next Steps

There was agreement, and even enthusiasm, to work together to look for local solutions. In addition to ensuring the necessary leadership to move ahead, there is a need to develop an adequate communication network to inform everyone about what's happening. It will be easier and more effective to work together with better communication about what others are doing.

A summary of the Summit will be prepared and circulated.

Work on local solutions will continue over the summer and, if all goes well, a Health Access Summit II will be held in the fall.

Jefferson Health Access Summit 2001

Participants

Ann	Avary	Economic Development Council
Jean	Baldwin, ARNP	Jefferson County Health & Human Services
Katherine	Baril	WSU Cooperative
David	Beatty	Olympic Area Agency on Aging
Jill	Buhler	Jefferson County Board of Health
Tim	Caldwell	Port Townsend Chamber of Commerce
Terri	Camp	Jefferson General Hospital
Robert	Campbell	Jefferson General Hospital
Mary	Conway	Office of Senator Patty Murray
Julia	Danskin	Jefferson County Health & Human Services
Anthony	De Leo	Jefferson General Hospital Commissioner
Vic	Dirksen	Jefferson General Hospital
Paula	Dowdle	Jefferson General Hospital
Patsy	Feeley	Office of State Senator Jim Hargrove
Roberta	Frissel	Jefferson County Board of Health
Leo	Greenawalt	Washington State Hospital Association
William	Hagens	Office of Insurance Commissioner
Tom	Hagens, DDS	Dentist
Jenny	Hamilton	Office of Financial Management
Kathy	Hill	Commissioner Jefferson General Hospital
Tim	Hockett	Olympic Community Action Program
Janet	Huck	The Leader
Glen	Huntingford	Jefferson County Commissioner
Claus	Janssen, MD	Olympic Primary Care
Jennifer	Johnson	PT Paper Company
Nadine	Jonientz	Fleet Marine, Inc.
Aaron	Katz	Univ. of Washington Health Policy Analysis Program
Kris	Locke	Policy Analyst

Tom	Locke, MD	Jefferson County Health & Human Services
Tom	Luce	Office of Congressman Norm Dicks
Geoff	Masci, DC	Mayor, Port Townsend
Bill	Matheson, MD	KPS Health Plans
Melanie	McGrory, MD	Olympic Primary Care
Bob	Peden	United Good Neighbors
Debby	Peterman	Peterman and Associates
Cory	Reddish, ND	Olympic Naturopathic Clinic
Bill	Riley	Jamestown S'Klallam Tribe Health & Human Services
Chuck	Russell	Jefferson General Hospital Commissioner
Charles	Saddler	Jefferson County
Ree	Sailors	Office of the Governor
Jon	Shelton	Frontier Bank
Brent	Shirley	Brent Shirley & Associates
Stacie	Simmons Bates	KPS Health Plans
Sandra	Smith-Poling, MD	EMS Medical Program Director
Lorna	Stone	Washington Health Foundation
Elinor	Tatham, MD	Physician
Dan	Titterness	Jefferson County Commissioner
Greg	Vigdor	Washington Health Foundation
Philip	Watness	Peninsula Daily News
Sheila	Westerman	Jefferson County Board of Health
Joseph	Wheeler	Jefferson General Hospital Commissioner
Vicki	Wilson	Office of Financial Management
Richard	Wojt	Jefferson County Commissioner

Jefferson Health Access Summit 2001
Evaluation and Comments

Total number of evaluations = 26
Total number of participants = 52

1. Did you learn new information about health access issues today?

23 - yes **2 - no**

What was most interesting to you?

- Doctors are independent. Need to band together and network more with other health provider groups in town. How about if they get AARP on their bandwagon for Medicare.
- Physician input.
- Need for clear understanding of how system works, what $ are used for.
- Discussion of various possible solutions.
- Different perspectives presented and level of participation.
- Good statistics. That the meeting happened at all and the potential collaboration.
- The possibility of a community-wide health care plan.
- The numbers. How physicians are reimbursed, What portion of the local, state, national economy is actually made up of the health industry.
- The overwhelming will to <u>do</u> something.
- The panelists – they were excellent esp. keeping on time.
- The concept of local socialized medicine was acceptable.
- Medical – health care – continuum of planning and problems, solutions.
- The discussion that has already been going on – the need for further work – political will.
- All.

2. On a scale of 1-5, to what extent do you think our health system is in distress? (circle one below)

No distress	Minor	Moderate distress	Serious	Critical distress
1	2	3	4	5

Average = 4.2

There's plenty $/there's plenty interest – Just co create system driven by health and ins.

3. Do you agree with the health system design goals? (circle one below)

Don't agree	Slightly	Generally agree	Strongly	Completely agree
1	2	3	4	5

Average = 3.8

Why?

- Seems logical need to structure bite size steps.
- Not much help – Good win-win ground rules but not motivating as goals.
- Our small group determined that some of the goals collide (i.e. access and quality).
- I do question the administrative functions section. In terms of the formation of an entity that manages administrative functions.
- Need some "right brain" thinking".
- I guess it is good to start in an idealistic way but it doesn't seem very practical or realistic (gotta try).
- I'm sure as a first draft we will streamline and detail this list more – It's a great start.
- Model/integrate with Institute of Medicine (national) guidelines for health care system restructure.

4. Should Jefferson County residents look for community based solutions?

26 - yes **none - no**

Why?

- Power is local.
- We live with consequences of poor health.
- State and federal governments do not have the political will for this.
- As an isolated rural community with a diminishing employer/employee base our "individual" community members are becoming our health care access leverage.
- A small community is often better equipped to address these issues in a way that meets the needs of that community.
- It seems the most workable solution – the state and feds aren't doing much.
- What options?
- What other choice do we have?
- I strongly believe in the community access program approach to increasing access and quality of health care services.
- The expenses are community expenses.
- Demonstration projects can be funded and implemented.
- Things are only going to get worse. We need to find the solution ourselves.
- State and feds don't care – dominated by interest that are contrary to our interest.

What other comments do you have that you'd like to have included in the written Summary from today's Summit?

- I'm looking forward to health access summit II and some action items. Thank you.
- Very well done.
- De-bureaucratize the system.
- Not just another study and report please – create some kind of action process.
- Investing in subscriptions for an on-line health education service like Medline would be worthwhile.